U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 12 July 2006

CASE NO. 2005-BLA-5114

In the Matter of

DAVID L. SHORT, SR.,
Claimant,

v.

KEYSTONE COAL MINING CORP.,
Employer,

and

ROCHESTER & PITTSBURGH COAL CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Robert J. Bilonick, Esquire
For the Claimant

George H. Thompson, Esquire
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the Act). (DX 1)[1]. The Act and implementing regulations, 20 C.F.R. Parts

[1] The following abbreviations are used in this opinion: DX = Director's exhibit, EX = Employer's exhibit, and TR = Transcript of the November 2, 2005 hearing.

410, 718, and 727 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis, or CWP) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

PROCEDURAL HISTORY

Claimant filed his claim for benefits with the Department of Labor (DOL) on August 28, 2003. (DX 2). The District Director issued a Proposed Decision and Order on July 14, 2004, in which he denied the claim for failure to establish the existence of coal workers' pneumoconiosis and a totally disabling respiratory impairment due to the disease. (DX 32). On July 19, 2004, Claimant objected to the findings of the District Director and requested a formal hearing before an Administrative Law Judge. (DX 35).

On November 2, 2005, I held a hearing in Pittsburgh, Pennsylvania. The Claimant and Employer, both represented by counsel, were afforded the full opportunity to present evidence and argument. I admitted Director's exhibits 1–40, Claimant's exhibits 1–2, and Employer's exhibits 1-12. (TR 5–6). Post-hearing, Claimant's exhibit 3, consisting of the deposition transcript of Dr. Begley was admitted into evidence. Employer submitted a reading by Dr. Hayes of the July 28, 2005 x-ray, post-hearing, which is hereby admitted into evidence as Employer's exhibit 13. Employer has submitted a post-hearing brief. The record is now closed.

The parties stipulated to Employer's proper designation as the Responsible Operator, to at least eleven years of qualifying coal mine employment by the Claimant, and to the qualification of one dependent, Claimant's wife Donna, for purposes of augmentation of benefits. (TR 6–7). Additionally, in its post-hearing brief, Employer conceded the issue of total disability.

ISSUES

(1) Whether the miner worked at least fourteen years in or around one or more coal mines;
(2) Whether the miner has pneumoconiosis;
(3) Whether the miner's pneumoconiosis arose out of his coal mine employment; and
(4) Whether the miner's disability is due to pneumoconiosis.

(DX 38, TR 6-7).

FINDINGS OF FACT

Length of Coal Mine Employment

As noted, Employer has stipulated to eleven years of coal mine employment. At the hearing, Claimant alleged twelve years of coal mine employment. (TR 6). The Director found 11.05 years of coal mine employment. (DX 32). Claimant testified to several breaks in his coal mine employment due to back surgeries. (TR 9). I find, based upon the stipulation of Employer, the evidence of record, and Claimant's testimony, that the evidence of record establishes that Claimant was a coal miner within the meaning of the Act and Regulations for at least eleven years. (DX 4, 5).

Responsible Operator

The parties agree and I find that Keystone Coal Mining Corp. is the last employer for whom the Claimant worked a cumulative period of at least one year. Therefore, Employer is the properly designated responsible coal mine operator in this case.

Dependents

I find that Claimant has one dependent for purposes of augmentation of benefits under the Act, namely his wife, the former Donna Lee Albright. (DX 7; TR 8).

Claimant's Testimony

The Claimant was born on November 14, 1943. (DX 2; TR 8). He testified that he worked as a coal miner from 1975 to 1989, but due to back injuries, his mining was interrupted. (TR 9). He currently receives a disability pension. (TR 10). His last job in the coal mines was as a miner operator/bolter helper. (TR 10). His employment involved hard manual labor. Claimant left the job because of a back injury. (TR 11). Claimant testified that he has been bothered with coughing for the past year or two. (TR 12). He has had breathing problems which have worsened for the past couple of years and has been on breathing medication since 2000 or 2001. (TR 12-13).

The Claimant testified that his family physician is Dr. Sillaman. (TR 13). Claimant uses Albuteral and a dual nebulizer. (TR 13). Claimant has had double bypass surgery and stomach surgery. (TR 15, 17-18). Claimant quit smoking in 2002, having started smoking in 1962. (TR 16). He consumed about a pack of cigarettes per day. (TR 16).

Medical Evidence

Chest X-rays

Exh. #	X-ray Date	Physician/Qualifications[2]	Interpretation
DX 17	2/9/04	Boron, Board-eligible radiologist	No pneumo
DX 18	2/9/04	Navani	Quality 1
EX 2	2/9/04	Hayes BCR, B	No pneumo
EX 1	1/26/05	Mital BCR, B	p/p, 0/1
CX 1	7/28/05	Begley	Simple pneumoconiosis
EX 13	7/28/05	Hayes BCR, B	0/0

Pulmonary Function Studies

Exh. #/ Physician	Date	Age/Height	FEV1	MVV	FVC	Qualify?	Impression
DX 14 Illuzzi	2/12/04	60/66.5"	1.07	44	1.89	Yes	There is moderate to severe obstructive airways disease
EX 1 Pickerill	1/26/05	61/65"	1.04 1.17*		1.70 2.45*	Yes Yes	Severe obstructive defect. Significant improvement in the FEV1 and FVC results after bornchodilators
CX 1 Begley	7/28/05	61/67"	0.84 0.99*		1.92 2.37*	Yes Yes	Severe obstructive lung disease with significant air trapping and improvement post-bronchodilator

*post-bronchodilator

[2] The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. § 37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii).

A pulmonary function study was conducted during Claimant's hospitalization in December of 2002. (EX 6). It does not include tracings and produced an FVC of 2.16 and an FEV1 of 1.20. Dr. Rogers found that it was indicative of a moderate airways obstruction, air trapping, and anatomic emphysema.

The study conducted by Dr. Illuzzi on February 12, 2004 was found to be valid by Dr. Kucera, who is board-certified in internal medicine, pulmonary diseases, and critical care medicine. (DX 15, 16). Dr. Begley failed to provide tracings with his July 28, 2005 study.

Arterial Blood Gas Studies

Exh. # Physician	**Date**	**pCO2**	**pO2**	**Qualify?**	**Impression**
DX 13 Dr. Illuzzi	2/12/04	42.2 42.7*	74.1 91.1*	No No	
EX 1 Pickerill	1/26/05	44 50*	69 30	No Yes	Satisfactory resting arterial blood gases on room air. Significant reduction in pO2 and oxygen saturation during exercise consistent with exercise-induced hypoxemia
CX 1 Begley	7/28/05	44 49*	79 81*	No No	

*post-exercise

Physicians' Reports

Dr. Thomas Hayes, who is a B-reader and board-certified in radiology, reviewed a CT scan taken on January 26, 2003. (EX 3). He found it to show no evidence of occupational pneumoconiosis. He also reviewed a CT scan taken on May 30, 2004, finding evidence of bullous emphysema with no evidence of clinical pneumoconiosis.

On February 12, 2004, Dr. Angelo Illuzzi examined Claimant. (DX 12). He considered a coal mine employment history from 1979 to 1989, Claimant's last position being that of a general laborer/bolter helper/bolter operator. He also took into account a smoking history of one pack of cigarettes a day from 1962 to 2002. Claimant complained of sputum production, wheezing, dyspnea, cough, orthopnea, ankle edema, and paroxysmal nocturnal dyspnea. Claimant provided a medical history significant for pneumonia, attacks of wheezing for the past two years, chronic bronchitis, arthritis, heart disease, allergies, cancer of the skin, and high blood pressure.

Dr. Illuzzi conducted an x-ray, a pulmonary function study, a blood gas study, and an EKG. Based upon his examination, he diagnosed (1) severe chronic obstructive pulmonary disease on spirometry; (2) coronary artery disease; (3) S/P aortic valve replacement; and (4) hypertension. Dr. Illuzzi found the first condition to be secondary to his forty pack year history of tobacco abuse and coal dust exposure. In his opinion, the Claimant was totally disabled from

his prior coal mine employment work due to multiple causes, "i.e. severe COPD, heart disease, spinal degeneration and generalized debility. There is no pulmonary parenchymal pneumoconiosis present."

On January 26, 2005, Dr. Robert G. Pickerill examined Claimant. (EX 1). He also had the opportunity to review medical records. Dr. Pickerill recorded twelve years of coal mine employment and a smoking history of one pack of cigarettes per day for forty-two years, Claimant having quit smoking in 2002. Based upon his examination, which included the taking of histories, chest x-ray, pulmonary function testing, blood gas studies, and electrocardiogram, Dr. Pickerill diagnosed (1) severe chronic obstructive pulmonary disease due to previous tobacco smoking; (2) pulmonary emphysema by CT scan of the chest of 5/30/04 reported by Dr. Hayes; (3) no radiographic evidence of coal workers' pneumoconiosis; (4) aortic valve replacement for aortic stenosis on 12/19/02; (5) double coronary artery bypass surgery for coronary artery disease on 12/19/02; (6) chronic arterial hypertension; (7) hyperlipidemia; and (8) chronic cervical and lumbar spinal stenosis and myelopathy. It was his opinion that Claimant had a significant functional respiratory impairment, which he attributed to COPD and emphysema from previous tobacco smoking. In his opinion, the disability was severe enough to prevent coal mine employment from a respiratory standpoint. That impairment, however, was not due to coal workers' pneumoconiosis or an occupational lung disease. Dr. Pickerill is board-certified in internal medicine, pulmonary diseases, and critical care medicine.

The deposition of Dr. Pickerill was taken on October 19, 2005. (EX 12). Dr. Pickerill reiterated his diagnosis as listed above. He noted that he found no evidence of pneumoconiosis based on the negative chest x-rays. He further explained that Claimant's pulmonary function testing showed severe obstructive defect and the lung volume showed hyperinflation and increased lung volumes, which he stated is typical for obstructive lung diseases. However, he noted that coal workers' pneumoconiosis is a chronic fibrotic pulmonary disease and would be expected to cause decreased lung volumes and restrictive lung disease. He also pointed to the partial improvement after bronchodilators, which is typical of an individual who has COPD from tobacco smoking. Dr. Pickerill noted that Claimant did not have treatment for his lung disease until 2000, some eleven years after he stopped working in the coal mining industry. In his opinion, the development of obstructive lung disease was more correlated with the length of cigarette smoking, relative to his fewer years in coal mining. Claimant primarily had pulmonary emphysema directly related to his cigarette smoking. Dr. Pickerill testified to his reading of a chest x-ray, noting that he is a B-reader. However, his reading exceeds the evidentiary limitations, and therefore, his testimony regarding that reading will not be set forth herein.[3]

[3] Amendments to the Part 718 regulations became effective on January 19, 2001. The 2001 amendments significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. *Id*. In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy or autopsy. § 725.414(a)(2)(ii). Likewise, employers and the District Director are subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i, iii). Employer herein has already submitted two x-ray readings as his affirmative evidence.

Dr. Pickerill testified that the pulmonary function studies had findings typical for obstructive lung disease due to cigarette smoking, not for a fibrotic lung disease such as coal workers' pneumoconiosis. Dr. Pickerill found Claimant totally disabled from a pulmonary impairment and agreed that coal dust exposure could cause obstructive disease and contribute to COPD or chronic bronchitis and emphysema. Dr. Pickerill explained, however, that he could not attribute a significant degree of coal dust exposure to Claimant's impairment. He stated that his opinion would change significantly if Claimant had a positive chest x-ray. Dr. Pickerill pointed to the absence of any significant treatment between the time of his retirement and 2000, which made it much more likely that Claimant's disease was related to the smoking than to coal dust exposure. He found Claimant's chronic obstructive pulmonary disease to be primarily pulmonary emphysema, pointing to the findings on CT scan and pulmonary function testing.

Claimant was examined on July 28, 2005 by Dr. Christopher J. Begley, who is board-certified in internal medicine, pulmonary disease, and critical care medicine. (CX 1, 2). Dr. Begley recorded that Claimant had been short of breath for some time. A cigarette smoking history of forty years at the rate of one pack of cigarettes per day was recorded, Claimant having quit smoking three years ago. Twenty-four years of coal mine employment was also recorded. Based upon his examination, Dr. Begley diagnosed (1) chronic obstructive pulmonary disease; (2) history of smoking; (3) coal workers' pneumoconiosis; (4) chronic bronchitis; (5) status post aortic valve replacement; and (6) status post coronary bypass surgery. Dr. Begley remarked that Claimant had significant obstructive lung disease as well as chronic bronchitis and coal workers' pneumoconiosis. He noted that the chest x-ray revealed evidence of simple pneumoconiosis.

The deposition testimony of Dr. Begley was taken on January 11, 2006. (CX 3). Dr. Begley reiterated his opinion as noted above. Dr. Begley also stated that he made an error when calculating Claimant's years of coal mine employment and that Claimant had twelve years of coal mine employment, not twenty-four years. This, however, did not alter his findings. He further stated that Claimant had a significant smoking history of forty pack years at the rate of one pack per day. It was his opinion that Claimant suffered from coal workers' pneumoconiosis as well as pulmonary emphysema and chronic bronchitis. Coal dust exposure and tobacco products both were the cause of Claimant's pulmonary emphysema. Claimant's chronic bronchitis and his pulmonary emphysema, due to both etiologies, were significant factors in his pulmonary impairment. In his opinion, Claimant was disabled from a pulmonary standpoint and could not return to his prior coal mine employment.

Dr. Begley stated that he had the opportunity to review medical records, including the report and testimony of Dr. Pickerill. Dr. Begley stated his agreement with the assertions made by Dr. Pickerill, namely, that Claimant's disease was more related to smoking and that Claimant primarily had pulmonary emphysema. Dr. Begley explained, however, that in his opinion, coal dust could not be excluded as a cause of Claimant's progression of symptoms, given that coal workers' pneumoconiosis is a progressive disease. He pointed out that an individual does not need to have a pulmonary impairment when he leaves the mines in order for him to develop significant pulmonary disability from coal dust exposure. Dr. Begley stated he could not give precise percentages of the contribution made by the two etiologies. On cross-examination, Dr. Begley affirmed that he was unable to distinguish between the impairment and disability due to cigarette abuse as opposed to coal mine dust exposure. He agreed that emphysema was the

major cause of Claimant's pulmonary complaints and disability. He also agreed that, other than what he saw on x-ray, all of the Claimant's complaints and physical findings on exam and the findings on pulmonary function testing were consistent with emphysema due to cigarette smoking. Dr. Begley explained the indicators that Claimant's COPD was contributed to by coal mine dust exposure: the abnormal x-ray findings, his exposure to heavy dust while working in the coal mines, and the fact that coal dust can contribute to chronic bronchitis and chronic obstructive lung disease. He also conceded that his diagnosis of chronic bronchitis was made based on Claimant's history.

Treatment Records

Treatment records from Latrobe Area Hospital, dating from 1978 have been submitted. (EX 5) Claimant was hospitalized on March 15, 1978, for a back injury. The discharge diagnosis was low back pain. Dr. Miller listed an Impression of "chronic low back pain, unknown etiology, doubt disc disease."

Claimant was hospitalized at University of Pittsburgh Medical Center on December 17, 2002 for aortic stenosis and coronary artery disease. (EX 6). It was noted that he was suffering from rapidly progressive multi-system failure. Chest x-rays were taken during this hospitalization for purposes other than diagnosing and classifying pneumoconiosis. The principal diagnosis was aortic valve disorder, with the secondary diagnoses including congestive heart failure, chronic airway obstruction, cardiac complication, atrial fibrillation, atrial flutter, acute vascular insufficiency of intestine, paroxysmal ventricular tachycardia, cardiogenic shock, ascites, other pulmonary insufficiency not elsewhere classified, and coronary artherosclerosis of native coronary vessel. Claimant underwent replacement of the aortic valve. Dr. John A. Kellum indicated on December 19, 2002 that he was seeing this "critically-ill patient" for management of hemodynamic instability status post coronary artery bypass surgery and aortic valve replacement. It was noted that Claimant had a history of chronic obstructive lung disease on corticosteroids. Dr. Ronald Pellegrini performed an aortic valve replacement and double bypass surgery on December 19, 2002.

On December 21, 2002, Claimant underwent a mediastinal re-exploration, insertion of intra-aortic balloon pump. (EX 6). The diagnosis was biventricular dysfunction and pulmonary hypertension. Dr. Lawrence Wei recorded that Claimant suffered from severe chronic obstructive pulmonary disease, severe aortic stenosis, coronary artery disease, and that he underwent aortic valve replacement and coronary artery bypass grafting two days ago. Dr. Penny Lynn Sappington also saw Claimant at the time, managing him for heart failure, volume overloaded state, and electrolyte abnormalities. An evaluation for lung disease was rendered by Dr. Oh Kook Sang on December 23, 2002. The Impression did not include mention of pneumoconiosis. On January 3, 2003, Dr. Boujoukos indicated he was seeing the "critically ill man in follow-up of recurrent atrial arrhythmias, cardiomyopathy, and respiratory insufficiency." On January 4, 2003, Dr. Boujoukos saw Claimant for follow-up for anticoagulation, respiratory insufficiency, cardiomyopathy, and atrial fibrillation. (EX 6). Dr. Boujoukos noted that from a respiratory standpoint, the Claimant had progressed well. He still appeared to be mildly labored on two liters of nasal cannula, had been a heavy smoker, and worked in coal mines.

Claimant was hospitalized at Latrobe Area Hospital on February 11, 2003 and discharged on February 20, 2003. (EX 7). The handwritten pages contained in this record are illegible. Claimant was suffering from small bowel obstruction, bowel ischemia and underwent an exploratory laparotomy with small bowel resection and anastomosis, lysis of adhesions. Chest x-rays were taken which were not read for the purpose of diagnosing pneumoconiosis. The principal diagnosis on discharge included small bowel obstruction with other significant diagnoses of (1) intestinal ischemia; (2) S/P aortic valve replacement; (3) chronic anemia; (4) chronic obstructive pulmonary disease; and (5) coronary artery disease status post bypass. Drs. Lorenzo Bucci and James W. Sillaman were the treating physicians.

On May 14, 2003, Claimant was again hospitalized at Latrobe Area Hospital. (EX 8). The discharge diagnosis rendered by Dr. Sillaman included (1) atypical chest pain; (2) abdominal pain with CT scan pending, suspect irritable bowel syndrome; (3) coronary artery disease with history of coronary artery bypass graft; (4) prosthetic aortic valve; (5) chronic obstructive lung disease; and (6) hypertension.

On September 15, 2003, Claimant was hospitalized. He was discharged on September 17, 2003 with a principal diagnosis of exacerbation of chronic obstructive pulmonary disease. (EX 9). The "Other Significant Diagnoses" included (1) coronary artery disease; (2) atypical chest pain; (3) foreign body left eye; (4) prosthetic aortic valve; and (5) hyperlipidemia. Upon admission, Claimant indicated that his chest pain was worse when he coughed. It was recorded that he was an ex-smoker. Numerous pages are handwritten and illegible. Chest x-rays were taken but were not read for the purposes of classifying pneumoconiosis.

Dr. Lawrence Wei wrote to Dr. Szable on February 7, 2003 and indicated that the Claimant was seen for follow-up of his aortic valve replacement and double coronary artery bypass grafting. (EX 10). Dr. Wei stated that he was extremely pleased with Claimant's recovery.

In a letter dated March 16, 2005, Dr. Edward Szabo stated that he saw Claimant for a follow-up. (EX 11). Claimant remained stable. He was encouraged to avoid smoking and to try exercising.

CONCLUSIONS OF LAW

Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202–718.205; *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Evidence which is in equipoise is insufficient to sustain the Claimant's burden of proof. *Director, OWCP v. Greenwich Collieries, et al.*, 512 U.S. 267 (1994); *aff'g sub nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993).

Pneumoconiosis and Causation

The Regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

> Those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silico-tuberculosis, arising out of coal mine employment.

Id. Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae" if that disease or impairment arises from coal mine employment. *Id.* A claimant's condition "arises out of coal mine employment" if it is a "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* Finally, the Regulations reiterate that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust ceases. *Id.*

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987). However, this rule is not mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320.

The Regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)–(4). In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Under the provisions of 20 C.F.R. § 718.202(a)(1), chest x-rays that have been taken and evaluated in accordance with the requirements of § 718.102 may form the basis for a finding of the existence of pneumoconiosis if classified in Category 1, 2, 3, A, B, or C under an internationally-adopted classification system. An x-ray classified as Category 0, including subcategories 0/-, 0/0, and 0/1, does not constitute evidence of pneumoconiosis. Under § 718.202(a)(1), when two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays. *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 536 (4th Cir. 1998).

The record contains a total of six x-ray readings, only one of which was positive for pneumoconiosis. For cases with conflicting x-ray evidence, the Regulations specifically provide,

> Where two or more x-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 C.F.R. § 718.202(a)(1); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually-qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

In this case, Dr. Begley found the x-ray he read to be positive for pneumoconiosis. He is neither a B-reader nor a board-certified radiologist. He further indicated in his deposition testimony that he did not provide a classification pursuant to the ILO classification system. By contrast, Dr. Hayes, who is a B-reader and a board-certified radiologist, found that x-ray to be negative, as well as the July 28, 2005 x-ray. Dr. Boron also found the x-ray he read to be negative, and Dr. Mital found the January 2005 x-ray to be negative. Dr. Mital is also a dually-qualified physician. Dr. Begley's is the only positive reading of record. I credit the negative interpretation of the July 28, 2005 x-ray by Dr. Hayes over the positive interpretation of Dr. Begley's due to Dr. Hayes' high qualifications. Thus, the overwhelming weight of the x-ray evidence is negative for pneumoconiosis. Accordingly, I find that the existence of pneumoconiosis has not been established pursuant to 20 C.F.R. § 718.202(a)(1).

As there is no autopsy or biopsy evidence of record, Section 718.202(a)(2) does not apply. Under 20 C.F.R. § 718.202(a)(3), a claimant can establish that he is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.304 does not apply because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Section 718.306 is not relevant because it is only applicable to claims of deceased miners.

Under 20 C.F.R. § 718.202(a)(4), a claimant may also establish the existence of pneumoconiosis, notwithstanding negative x-rays, by submitting reason medical opinions. However, this regulation further provides that any such finding by a physician must be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories. Thus, the Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented

if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields, supra.*

Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The treatment records make mention of chronic obstructive pulmonary disease but do not diagnose coal workers' pneumoconiosis. Dr. Hayes reviewed CT scans and found evidence of bullous emphysema but no evidence of clinical pneumoconiosis. Dr. Illuzzi found Claimant's pulmonary disability to be the result of tobacco abuse and coal mine dust exposure. He did not, however, explain how he is able to reach this conclusion regarding etiology. I find his opinion lacking in reasoning and support, such as to render it worthy of little weight on this issue.

Dr. Pickerill finds severe chronic obstructive pulmonary disease and emphysema secondary to tobacco abuse. He opines that coal mine dust exposure has not contributed to the impairment. He points to several factors upon which he relies, including the findings on CT scan, the length of the smoking history as opposed to the length of exposure to coal mine dust, that Claimant had partial improvement on pulmonary function testing after bronchodilators, and that Claimant exhibited hyperinflation of the lungs, as diagnosed by the increased lung volumes. Dr. Pickerill opined that the hyperinflation is typical for obstructive lung disease due to cigarette smoking. By contrast, Dr. Begley finds significant chronic obstructive pulmonary disease and chronic bronchitis due to coal mine dust exposure and tobacco abuse. He further finds pneumoconiosis by chest x-ray. As noted above, I do not find his opinion regarding pneumoconiosis by chest x-ray persuasive. It was also his opinion, however, that Claimant's chronic bronchitis and pulmonary emphysema were the result of coal dust exposure and tobacco abuse. Dr. Begley agreed with Dr. Pickerill that Claimant's disease was more related to his smoking history than to his history of coal mine dust exposure and that Claimant's disease was primarily pulmonary emphysema. Dr. Begley, however, also found it to be due to coal mine dust exposure. Dr. Begley stated that he could not give precise percentages to the two etiologies and that he was unable to distinguish between the impairment and disability due to tobacco abuse as opposed to coal mine dust exposure. He also stated that, other than what he saw on chest x-ray, all of Claimant's complaints and physical findings were consistent with emphysema due to cigarette smoking and conceded that his diagnosis of chronic bronchitis was by history only.

Dr. Begley attributed part of Claimant's pulmonary condition to his heavy exposure to coal dust while working and because coal dust can contribute to chronic bronchitis and chronic

obstructive pulmonary disease. Dr. Begley opined that, given the progressive nature of the disease, he could not exclude pneumoconiosis as a factor. In sum, Dr. Begley relied on Claimant's heavy dust exposure in his coal mining employment, his abnormal x-ray findings, and the fact that coal dust can contribute to chronic bronchitis and chronic obstructive lung disease in reaching his conclusion on the issue of the etiology of Claimant's respiratory impairment. At the same time, he concedes that he cannot differentiate between the etiologies to which he attributes Claimant's pulmonary disease.

When reviewing the medical opinions of Drs. Pickerill and Begley, I find Dr. Pickerill's opinion to be the more persuasive. Dr. Begley relies on years of coal mine employment and what he finds to be a positive chest x-ray, to reach his conclusions. Thus, his diagnosis of pneumoconiosis appears to be based, in great part, on his own reading of a chest x-ray and Claimant's history of dust exposure. Having credited Dr. Hayes' negative interpretation of the July 28, 2005 x-ray over that over Dr. Begley, I find the medical evidence does not support his opinion.

Furthermore, the Benefits Review Board (the Board) has held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993*)(citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113(1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone "does not tend to establish that he does not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Id.* While Dr. Begley relies heavily on his positive x-ray reading and Claimant's years of coal mine dust exposure to conclude that Claimant's chronic pulmonary diseases are due, in part, to coal mine dust exposure, he also admits that he cannot differentiate between the two possible etiologies. He then proceeds to state that smoking was the greater factor in Claimant's disease. How he can make these determinations when, at the same time, he claims to be unable to differentiate between the two etiologies is not clear.

Upon reviewing the opinions of these two physicians, I find that of Dr. Pickerill to be the better reasoned and better documented. He explains his conclusions in light of the objective laboratory data, pointing to that which supports his conclusions. By contrast, Dr. Begley appears to rely, as noted, on Claimant's history of coal dust exposure and his positive x-ray reading while conceding he cannot otherwise explain how he reaches his conclusions regarding the etiology of the Claimant's pulmonary impairment. That pneumoconiosis is a progressive disease does not mean that a pulmonary condition which manifests itself after an individual has ceased coal mine employment is automatically considered to be the result of that employment. There must be support for that conclusion. Thus, while, Section 718.201 defines, "legal pneumoconiosis" to include any chronic lung disease or impairment arising out of coal mine employment, a well-reasoned medical opinion must provide the link. Dr. Begley diagnosed chronic bronchitis based on the Claimant's history. It is a diagnosis which is not supported by the treatment records, and I find it to be conclusory and unreasoned. I find that his diagnosis of chronic bronchitis does not

constitute a diagnosis of legal pneumoconiosis. I further find his opinion regarding the etiology of Claimant's chronic obstructive pulmonary disease is not as well-reasoned as the opinion of Dr. Pickerill.

I find that Dr. Begley's opinion regarding the cause of Claimant's pulmonary impairment is not as persuasive as that of Dr. Pickerill who fully addressed Claimant's extensive smoking history, coal mine employment, clinical presentation, and symptoms, explaining how they supported his conclusion regarding the etiology of Claimant's impairment. I find Dr. Pickerill's opinion to be well documented. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). It is also well reasoned and based on persuasive argument regarding the effects of Claimant's smoking and coal mine employment histories on his pulmonary disease.

In reliance on the well-reasoned, well-documented opinion of Dr. Pickerill, supported as it is by the treatment records and objective laboratory data, I find that the Claimant has not established the existence of pneumoconiosis. As the existence of pneumoconiosis is the threshold issue in any claim for black lung benefits under the Act, entitlement to benefits under the Act is not established.

Cause of Pneumoconiosis

Had it been determined that the miner suffers from pneumoconiosis, it would also have to be determined whether the miner's pneumoconiosis arose, at least in part, out of his coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

I find that Claimant, with at least eleven years of coal mine employment, would be entitled to the rebuttable presumption at § 718.203. However, because he has not established the existence of pneumoconiosis, this issue is moot.

Total Disability Causation

Claimant must establish by a preponderance of the evidence that his total disability is due to pneumoconiosis. *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986) (*en banc*). The amended regulations require that the pneumoconiosis be a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Section 718.204(c)(1) sets forth that pneumoconiosis is a substantially contributing cause of disability if it either (1) has a material adverse effect on the miner's respiratory condition or (2) materially worsens a totally disabling respiratory impairment caused by a disease unrelated to coal mine employment.

Every physician finds Claimant to be totally disabled, an issue already stipulated to by Employer. I find that total disability has been established. However, in order to be entitled to benefits, Claimant would need to establish that the total disability was due to his coal mine employment. It is this finding which the evidence cannot establish. Relying upon the medical

opinion of Dr. Pickerill, I find that Claimant has failed to establish, by a preponderance of the evidence, that pneumoconiosis is a substantially contributing cause of his disability.

Conclusion

As Claimant has failed to establish pneumoconiosis or total disability due thereto, I conclude that he has not established entitlement to benefits under the Act.

Attorney's Fees

The award of attorney's fees under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation services rendered to him in pursuit of the claim.

ORDER

It is ordered that the claim of DAVID L. SHORT, SR. for benefits under the Black Lung Benefits Act is hereby DENIED.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).